Steps are now being taken to implement the national mental health program enacted by the Congress. Central to this effort is the community mental health center, an organizational form which has as yet unexplored potentialities. The nature of such a facility and its relation to public health philosophy and practice are examined here.

THE COMMUNITY MENTAL HEALTH CENTER— A PUBLIC HEALTH FACILITY

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CONGRESS enacted Public Law 88-164 in 1963. Title II of this law is the Community Mental Health Centers Act, which provides grants to states to assist in the construction of local public and nonprofit community mental health centers. The 89th Congress amended Title II and provided grants for initial staffing of comprehensive mental health centers.

These actions in two successive sessions of Congress were initiated by health messages, first from President Kennedy and then from President Johnson. They represented the culmination of nation-wide citizen and professional efforts which began after World War II. In 1946, public interest had stimulated Congress to pass the National Mental Health Act, which led to the establishment of the National Institute of Mental Health in 1949. For the first time, administrative machinery and professional leadership became available to support research in the field of mental health, training of personnel, and technical assistance to community mental health programs.

Again, in 1955, in response to public concern, Congress enacted the Mental Health Study Act, which led to the formation of the Joint Commission on Mental Illness and Health, a group of 36 national professional and lay organizations with an interest in mental health. The commission carried out the congressional mandate to study the mental health needs and resources of this country and, on December 30, 1960, presented to the Congress and the President its final report, "Action for Mental Health," which contained its findings and recommendations.

The Joint Commission's report stirred much discussion and debate. It appeared evident that congressional action would follow. What should be the form of this action, which would set new directions for mental health services and practice in this country? On the executive level, President Kennedy appointed a cabinet level committee* to study the report and make recommendations for action on the executive level.

In the interim, Congress authorized grants during fiscal years 1963 and 1964 to permit each state to study its mental health needs and resources, and to prepare a long-range comprehensive plan for mental health services. Every state will have completed its mental health plan by September, 1965.

On February 5, 1963, President Ken-

* The committee was composed of the secretary of labor, secretary of DHEW, and administrator of the Veterans Administration, assisted by representatives of the Council of Economic Advisors and Bureau of the Budget.

nedy sent to the Congress his Special Message on Mental Illness and Retardation. He said in this message, "Central to a new mental health program is comprehensive community care. Merely pouring Federal funds into a continuation of the outmoded type of institutional care which now prevails would make little difference. We need a new type of health facility, one which will return mental health care to the mainstream of American medicine and at the same time upgrade mental health services."

Congress took action on the President's recommendation by enacting Public Law 88-164 which established a new concept for providing mental health services.

Current Trends in Mental Health Practice

Psychiatric treatment services at the present time are provided almost entirely in the offices of psychiatrists in private practice and to a small extent by other professional private practitioners, in the psychiatric or other wards of general hospitals, in public and voluntary outpatient clinics, and in public and private mental hospitals. Those who can pay for services have a range of choice. They are usually treated by the same psychiatrist throughout the course of their illness. If needed, periods of hospitalization, usually in private mental hospitals or in voluntary general hospitals, tend to be brief and provide prompt intensive care. Pathways to and from the hospital are usually through medical referrals and channels.

The patient who cannot pay may find outpatient care in a public or low-cost voluntary clinic; he may find temporary care in a psychiatric ward of a public general hospital pending a decision regarding the necessity for transfer to a state hospital; in many communities, he may be held in jail or he may land in a public mental hospital.

The public mental hospital is still the major resource for the care of those who cannot pay for their own care. The pathway into the treatment facility is often through nonmedical auspices, such as the police, court, or welfare agency. The pathway out of the hospital is again through referral often to nonmedical sources, such as social agencies.

The disparity in the fate of those who can pay and those who cannot appears to be significant, both in terms of perception of mental disorders and in the treatment and management of these disorders. Hollingshead and Redlich pointed this out as early as 1958.[1] The mental health problems of the poor tend to be seen as social problems, whereas the more affluent have their mental health problems managed in a medical framework. Do the poor really have different kinds of mental health problems than the more affluent? A recent book, "Mental Health of the Poor," questions this assumption.[2]

A major factor which spurred public concern after World War II was the plight of the state mental hospitals which were overcrowded, understaffed, and operating on too small budgets. Although many public mental hospitals have moved from custodial to therapeutic care in the past 15 years, have decreased in size, and increased their staffs and operating budgets, treatment programs in these hospitals still have limitations. A third of the states have only one public mental hospital. For many patients, geographic distance means alienation from both family and community. In addition, a number of public mental hospitals are still primarily custodial institutions. In 1964, mental hospitals in 22 states were operating on a patient per diem under $6. (The average per diem in general hospitals was over $40.)

It was for the purpose of providing

an alternative to "outmoded" types of institutional care that President Kennedy proposed the concept of the comprehensive community mental health center.

The Concept of the Community Mental Health Center

The emergence of the comprehensive community-based mental health center is introducing a disturbing note in the established order, and is affecting private practitioners, outpatient clinics, state mental hospitals, and psychiatric wards in general hospitals. From experience thus far, it seems clear that the comprehensive community mental health center is a different kind of facility than any which now exists.[3] The differences encompass both philosophy and technic.

The center program has the following objectives:

To provide adequate care and treatment and to improve and extend mental health services for all who desire or require such service, especially for those who cannot afford to pay for their own psychiatric care.

To provide adequate mental health services to all who reside in areas where no such services are now available.

To carry out those public health mental health activities that may be applied on a community-wide basis and which seek to prevent mental illness, limit mental disability and promote mental health.

A study of Public Law 88-164 and its legislative history, as well as of the regulations promulgated to implement the act, indicates the following criteria for a mental health center:

Accessibility—The center is reasonably close to where people live with due consideration for differences arising in urban, suburban, and rural areas.

Availability—The center's services are available when people need service and without the necessity for going on a waiting list.

Comprehensiveness—The center provides a range of services to fit the specific needs of patients, families, and communities, including inpatient and outpatient care, partial hospitalization, emergency service, and community consultation and education. Additional services may include rehabilitation, precare and aftercare, diagnostic services, training, and research.

Continuity—The center provides services to the patient and his family as long as care is needed. To ensure continuity of care, the program is structured to permit easy flow of patients, clinical information and staff, when possible, between the various elements of service.

Planning—The services and program of the center are based on continuous surveillance and planning to meet community needs.

These criteria will permit the center to attain its objectives through the following services:

Diagnosis and treatment of patients and families—Arranged in such a way so as to be accessible, available, comprehensive, with continuity of care.

Training—Accredited training for mental health professionals, where feasible, and inservice training for center staff and for other professionals in the community who encounter mental health problems.

Research—When feasible, but in all cases to have program evaluation to assess the center's operation.

Community services to include (a) public information and education; case and program consultation to community agencies and professionals who deal with people who may have mental health problems or are involved with people passing through maturational processes and stresses of life; (b) community planning to provide a constant assessment of mental health needs, to develop and deploy resources to meet these needs, and to secure active participation in community-wide health, welfare, and related planning; and (c)

community organization activities which will lead to public understanding and support for the mental health program through legislative, social, economic, and other efforts.

The Mental Health Center—a Public Health Facility

It is the thesis of this paper that the community mental health center is basically a public health facility, and that by utilizing the philosophy and technics of public health, the center can make a substantial contribution to the total health of the community.

Public health is basically concerned with prevention, and with disease as it affects groups of people in a community. However, the approach to the group is through the individual patient. Public health seeks to use procedures which can be economically applied to large numbers of people with satisfactory outcomes expected for a high percentage of them. It uses health education technics to persuade individuals to avail themselves of the help they might need. Public health functions through organized community effort, has legal backing, and is financed mainly by public funds. Rooted in epidemiology and statistics, public health methods are based on continuing surveillance of the needs of the community.

How does the mental health center fit into the public health scheme? The provisions of Public Law 88-164 and the regulations issued to implement the act require that the center be located in a geographic area with a population of small enough size to permit adequate services for the entire area (75,000 to 200,000 people). Some services are provided on a group basis, but the individual approach is preserved in the diagnostic and treatment process. Administrative and clinical methods of case finding, screening, and precare seek to prevent disease where possible and to limit progression of disease in all cases. Public information and education services to lay and professional groups utilize health education technics and help people make use of existing resources. Most centers will require public funds obtained through organized community effort to meet the goal of serving a total community. The center will need to survey continuously the needs of its population, to seek out noxious situations that may predispose to a breakdown of social functioning, and look for opportunities to promote mental health. Maintaining suitable records will assist in this task of surveillance, and will also contribute to research on the natural history of mental illness and health.

The primary goal of a public health agency is prevention of disease. Unfortunately, at our present stage of knowledge, cure or prevention of mental illness or disorder is not possible, except in a few instances. In time, epidemiologic studies may lead to preventive technics.

A public health agency also has the responsibility for medical care when no other facilities exist, either by providing the care directly or by assisting in the establishment of needed public or private facilities under other auspices in the community. How will the mental health center fit into this scheme?

As noted above, there are two systems of care in this country determined by the patient's ability to pay for service. It has already been demonstrated that mental health centers can exist under either system.[3] Experience shows that the optimal type of organization for a center is one tailored to the existing circumstances and requirements of the individual community it serves.

There are a number of trends under way that relate to the development of the mental health center as a public health agency. Preventive medicine and the social aspects of illness and health are receiving increasing emphasis in

private medical practice. Similarly, public health departments are emphasizing programs in chronic disease, alcoholism, and other disease entities. The gap between preventive and therapeutic medicine is narrowing. This is especially true in the field of mental health, since in many localities the mental health resources are so limited that one agency or one professional must perform a range of services.

Another trend is the increasing number of mental health professionals in private practice in an increasing number of communities. Also the economic status of more people in this country is rising, and more people are therefore able to pay for private care. Recent labor-management negotiations in the automotive industry provide for mental health benefits to be made available to more people. Furthermore, the federal Medicare Bill and Social Security amendments, if enacted, will increase benefits for mental health care.

The mental health centers program will need to accommodate to these changes. In areas where private practitioners and facilities become available and the income level of the population is adequate, the center may devote less time to direct patient care, and spend more time on community service functions and preventive activities. The latter activities are not usually self-supporting and public funds are required to finance them. This trend is not unlike the experience of some public health departments where the treatment of tuberculosis and venereal disease, obstetric and pediatric care have been taken over by hospital clinics and privately practicing physicians, leaving the health department free to use its resources for preventive activities.

On the other hand, some center programs may become the major mental health network in the community, and develop both preventive and therapeutic programs in depth. This type of center may be public, private, or a combination of both, may be housed under one roof or involve a coordinated network of services housed under several roofs, and may include both public and private practitioners, voluntary hospitals and clinics, and other health and welfare agencies. This type of program is complex. Experimentation and demonstration are needed to study the evolution of this type of pattern.

A successful example of a limited demonstration is furnished by the Prince Georges County (Md.) Mental Health Study Center, an outpatient clinic and field laboratory established by the National Institute of Mental Health in 1948. At the time of its inception, no mental health facility or agency existed in the county. By 1963, a county mental health outpatient clinic, a county alcoholism clinic, a psychiatric ward in the county general hospital, and a very active county mental health association had been established, in addition to about 20 psychiatrists practicing full time or part time. The Mental Health Study Center now provides consultation to the patients and clients of professional personnel and community agencies; operates mental health consultation and inservice training programs for the schools and public health and welfare departments; carries out epidemiological studies and surveys, e.g., a long-term study of reading disability in elementary school pupils; and collaborates in county planning and community organization as a representative of mental health interests. The study center still provides direct patient care, accepting patients only from professional referral sources who use the center's services selectively.

Conclusion

The Joint Commission report disclosed the tremendous gap between mental health needs and resources in this

country. As a result of the report, a new national mental health program was proposed by President Kennedy and enacted by the Congress. President Johnson has supported and sought to extend the program.

We are now moving to implement this new nation-wide program. The mental health center provides a means for carrying out the goals of the new program. The center is an organizational form derived from experiment, research, and practical experience, as well as from the deliberations of the best informed professional and lay groups in the country.

The community mental health center is not a static entity. As experience grows and as social, economic, and technical resources change, the mental health center will also change. Tried and proven public health methods and philosophy embodied in the new approach will add strength and give direction to the new effort.

Ways must be sought to adapt and modify public health practice to fit the uniqueness of the wide range of mental disorders and the requirements for mental health. This will be no easy task in the present state of our limited knowledge. The comprehensive mental health center offers a framework that may facilitate the task.

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Opportunity for Canadian Student

The Department of Medical Care Organization, University of Michigan School of Public Health, in cooperation with the International Union, United Automobile Workers, announces a joint work-study program for a Canadian graduate student for the academic year 1966-1967. Students with backgrounds in the field of medical care, public health, hospital administration, or in the social sciences will be considered.

The program combines graduate study in the field of medical care organization with a half-time position in the Social Security Department, UAW, Detroit, Mich., in the development of medical care programs under collective bargaining. Stipend for the academic year will be $4,000.

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